

To the Editor:

I read the paper of Herbert A. Goldfarb (Goldfarb HA. Combining Myoma Coagulation with Endometrial Ablation/Resection Reduces Subsequent Surgery Rates. *JSLS*. 1999;3;253-260) with great interest.

Hysteroscopic myomectomy was found to be successful in treating menstrual symptoms caused by submucous fibroids in four out of five cases.¹

I have personally performed 112 endometrial resections between 1993 and 1996 of which the patients had submucosal fibroid(s) in 30 cases. Apart from two patients who wanted to conceive, the rest had endometrial resection as well as myomectomy. The fibroids were removed with a fibroid resectoscope (Karl Storz GmbH, Tutlingen, Germany) that had the capability of using a needle (instead of the loop or ball electrode) to inject anesthetic into the fundal area. This made it possible to perform the operation under local anesthesia (8% of the cases). The technique has been reported in the literature.² Although my study population is similar to only a part of the patients in Goldfarb's paper (resection and myolysis group), the comparison is edifying. There was only one point where I found a significant difference, namely the percentage of patients who needed further hysterectomy (17% versus 3.5%).

What are the reasons for this difference?

The follow-up period of my study was longer – 69 months (range, 38 to 86). Fifty percent of the patients who needed subsequent hysterectomy underwent the procedure within 24 months. The need for further surgery decreased with time. There were no patients in my study group who had repeated endometrial resection or myoma enucleation, but all

of them had abdominal hysterectomy. The decision for additional surgery was not made by the surgeon who performed the endometrial ablation, but by those who referred the patient for the initial procedure to our center.

There are two reasons noted for our difference. The first one is the longer follow-up period (69 versus 33 months), and the second reason is that the decision regarding long term management of the patients in my study group was not in my hands, but in those who referred the patients for operation to our center. Although in Goldfarb's study almost the same percentage of patients (18%) had further surgery due to inadequate symptomatic relief, only one patient (3.5%) had a hysterectomy.

It seems to be very important that the patient has to be followed by the same surgeon who performed the initial hysteroscopic procedure. In this way, even if further operative treatment is required, the treatment could be a repeated hysteroscopic, minimally invasive procedure, instead of a hysterectomy.

Sincerely,

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References:

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2. Hallez JP. Single-stage total hysteroscopic myomectomies: indications, technique and results. *Fertil Steril*. 1995;63:703-708.